ANNUAL MEETING
September 8-9-10, 1932
Royal Alexandra Hotel, Winnipeg

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MANITOBA MEDICAL BULLETIN

August, 1932

Vol. XII. No. 8

Manitoba Medical Association

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The Manitoba Medical Bulletin

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The Annual Meeting

To the Medical Profession of Manitoba:

THERE are a number of reasons why the approaching annual meeting to be held Thursday, Friday and Saturday, September 8th, 9th and 10th, in the Royal Alexandra Hotel, Winnipeg, will be so notable that all members of the Association should be present. The visiting speakers are all eminent in their special fields, and their subjects have been chosen with an eye to the needs of the general practitioner. The local speakers will present papers and clinical material that cover a wide range and will appeal to practitioners in all branches. Following the precedent set at the Brandon meeting, Thursday evening will be devoted to a joint meeting of the Manitoba Medical Association and the College of Physicians and Surgeons when any subject relating to the good and welfare of the profession can be discussed. The business meeting of the Association following the Friday luncheon will bring up questions of vital interest to the whole profession. Dr. R. Rennie Swan and his committee have some brilliant ideas which will ensure the social success of the annual dinner and dance on Friday evening, and the Ladies' Committee will provide entertainment for the visiting ladies. Last, but not least, Dr. Warner and his committee will provide fare for the medical golfers.

There never was a time in the history of the province when it was more necessary for the profession to present a united front. Remember, this is your meeting, and by your presence and enthusiasm you can make the meeting, despite the prevailing depression, the most successful yet.

Yours faithfully,

Ross Mitchell

President.

Annual Meeting
Manitoba Medical Association

September 8-9-10, 1932
Royal Alexandra Hotel, Winnipeg

Wednesday, September 7th.

Dinner to Retiring Executive, given by Dr. Ross Mitchell, Manitoba Club, at 7.00 p.m.

Thursday, September 8th.

9.00 a.m.—Registration.

10.30 a.m.—Dr. A. C. Abbott, Winnipeg—"Hyperthyroidism in Children."

11.15 a.m.—Dr. W. B. Hendry, Toronto—"Some Clinical Problems of Pregnancy and Child Birth."

12.15 p.m.—Luncheon to Guest Speakers.

2.15 p.m.—Dr. John Brodie, Winnipeg—"The Significance of Electro Cardiograms in Heart Disease" (with lantern slides).

3.00 p.m.—Dr. B. J. Brandson, Winnipeg—"Jejunal Ulcer."

3.45 p.m.—Dr. W. E. Gallie, Toronto—"Sprains and Dislocations."

4.30 p.m.—Dr. Geo. C. Hale, London—"Asthma."

8.00 p.m.—Open Meeting of the College of Physicians and Surgeons.

Friday, September 9th.

9.30 a.m.—Dr. O. S. Waugh and Dr. J. A. Hillsman, Winnipeg — Clinic: "Brain Injuries", including a Presentation of Cases.

10.45 a.m.—Dr. F. G. McGuinness, Winnipeg—"The Relief of Pain in Labour."

11.30 a.m.—Dr. W. B. Hendry, Toronto—"Hæmorrhage in the Early Months of Pregnancy."

12.15 p.m.—Luncheon and Annual Meeting. Presidential Address.

3.00 p.m.—Dr. W. E. Gallie, Toronto—"Acute Abdominal Emergencies in Childhood."

3.45 p.m.—Dr. H. E. Michelson, Minneapolis—"The Treatment of Syphilis."

4.30 p.m.—Dr. F. R. Miller, London—"Recent Advances in Functional Neurology."

7.00 p.m.—Annual Dinner and Dance."

Saturday, September 10th.

9.00 a.m.—Dr. W. A. Fansler, Minneapolis, and Dr. C. K. Petter, Oak Terrace, Minnesota—"Surgical Treatment of Rectal Tuberculosis" (with lantern slides).

9.45 a.m.—Dr. Geo. C. Hale, London—"Cardiac Pain."

10.30 a.m.—Dr. G. W. Fletcher, Winnipeg—"Tumours of the Throat."

11.15 a.m.—Dr F. R. Miller, London—"Recent Advances in Various Fields of Physiology."

2.00 p.m.—Golf Tournament.

Some Considerations Suggested by a Perusal *of* the Following Publications Dealing With Health Insurance

By W. Harvey Smith

1. "*International Studies on the Relation Between the Private and Official Practice of Medicine, with Special Reference to the Prevention of Disease*," by Sir Arthur Newsholme, late Principal Medical Officer, Local Government Board. Conducted under the auspices of the Milbank Foundation. Three volumes.
2. "*Medicine and the State*," by the same author.
3. "*Paying Your Sickness Bills*," by Michael M. Davis, Director of Medical Services of the Julius Rosenwald Fund, and a member of the Committee on the Cost of Medical Care.
4. "*The Real Meaning of Social Insurance*," by Hugh H. Wolfenden, Actuary, of Toronto; prepared for the Life Insurance Officers Association of Canada.
5. "*The Way of Health Insurance*," by A. M. Simons and Nathan Sinai, of the Research Staff of the Committee on the Study of Dental Practice, of The American Dental Association. Published by the University of Chicago Press.
6. "*Survey of Nursing Education in Canada*," by G. M. Weir, Head of the Department of Education, University of British Columbia. Carried on under the joint auspices of the Canadian Medical and the Canadian Nursing Associations.
7. "*Final Report of the Royal Commission on State Health Insurance and Maternity Benefits*," of British Columbia.
8. "*The Purchase of Medical Care Through Fixed Period Payments*," by Pierce Williams.
9. "*Economic Conditions in Medicine.*" Valedictory Address of Dr. A. S. Monro, immediate Past President of the Canadian Medical Association.

Limitations of space do not permit of an extended review of the publications above enumerated, but a brief reference to some of the points arising out their perusal may not be out of place.

It is maintained by many physicians, whose opinions are entitled to all respect, that the profession of medicine does itself a great dis-service by taking too seriously the oft heard assertion, coming from various sources, that the solution of many of the economic ills that beset us, must come from a socialization of practice, that proposals looking to the establishment of a system of state medicine, represent little more than the efforts of opportunist politicians to submit planks, that will obtain popular favor, and thereby ensure the continuance of their advocates in public life, and that the pre-

vailing method of offering medical care meets all the requirements of the public and the doctors. That these views are erroneous will, I believe, be demonstrated by a perusal of the works with which this article deals, and will reveal the existence of grave dissatisfaction with certain aspects of the basis upon which medical care is offered the public, and will suggest that medical practitioners cannot afford to ignore the economic trends of the period in which we are living, nor to disregard their momentous and potential significance.

The financial cataclysm through which we are passing has brought into clear relief the defects and the injustices of the economic system under which practice is conducted, thus in Manitoba approximately 600 doctors, 1/10 of 1% of the population, are giving their time, skill and energy to the needs of the indigent sick, to the value computed to be in excess of $2,000,000 annually. To this sum the proportion of overhead expense chargeable to the free work performed should be added. It should be noted that under the law the value of these contributions is not deductable in the payment of income taxes, as are subscriptions to churches and charities.

The physician of mature years and established practice, can afford to make a liberal contribution of time and service to the interests of the sick poor, but in the case of younger men, who have their professional spurs to win, practice under the existing system involves in scores of instances great economic hardship. A system under which 40% or more of sick people are cared for on a gratuity basis, surely indicates that the inexorable law of economic evolution is commencing to operate disadvantageously, to the younger members of the profession especially, and also to the public. Is the time not ripe for a re-appraisal of the principles and methods under which medical services should be offered the public?

The trying days we are passing through have demonstrated that the state or the community is fast developing a social conscience, and is prepared to accept the responsibility for feeding, clothing, housing and keeping warm, those of its citizens who are the victims of unemployment or bad luck. This is as it should be, but I submit that the public—below a certain income level, is entitled to organized medical care, and that practitioners, especially those who are recent graduates, have a real grievance in being expected to give their time and skill to the community without hope of material reward, and at considerable expense to themselves.

The standing and knowledge of those responsible for the publications above listed, are impressive, including as they do distinguished representatives of public health, economics, education, executive office, actuarial science, private practice and government opinion. The conclusions and recommendations presented — while they cannot be accepted unreservedly — constitute a contribution to the economics of medicine of a highly judicial and authoritative character. Let us very briefly note some of the contributions each of these publications makes towards clarifying the issues with which we are confronted. In passing let it be stressed that through legislative enactment the medical profession in each province have been granted the privilege and the responsibility of controlling medical education and licensure, and that if we should fail to meet our obligations — implied and actual — to the public, we may find ourselves over-ridden by legislation that will be extremely objectionable.

Sir Arthur Newsholme's four volumes, three of which were written at the instigation of the Milbank Foundation, deal with health insurance systems as carried on in fifteen European countries. He traces their development and history, and outlines the variations in practice and method that exist. The

student of health insurance will find these volumes to be a compendium of statistical knowledge and administrative detail of great authority, most excellently presented. The practical lesson that we may derive from their perusal, is that the wisdom of statesmen has been expressed often by the establishment of systems of medical care for those citizens who are below a certain income level, and whose health is regarded by the state as a matter of supreme economic importance. The introduction of the "Panel System" in Great Britain, without—in the initial stages—consultation with representatives of organized medicine, found the British Medical Association unprepared for the fight that followed, and whch cost it over $150,000. The lesson for us in this record is the necessity of maintaining at all times a competent organization, watchful of our interests, and prepared to ensure to the public the best possible medical care.

To the writing of *"Paying Your Sickness Bills,"* Michael M. Davis brings a wide and ripe experience in the field of medical administration and economics. Under the headings, *"The Burden of Sickness," "The Ability to Pay for Medical Care,"* and *"Evening the Burden,"* he deals interestingly and convincingly with the varied considerations groupable under these divisions. Quoting from the National Bureau of Economic Research he points out that 79% of incomes in the United States are below $2,000 a year. These figures must surely carry a great significance for the student of medical economics. In response to the question, "Can we budget for illness?" Dr. Davis says, "application of the budget principle to sickness, however, fails before the patent fact that sickness is neither a regularly recurring nor a predictable expenditure. Sickness cannot be budgeted by the individual family, it can be budgeted by a group." He insists that "The special need of middle economic groups is for insurance against high cost sickness," and that "Distributing sickness costs is essential, The method must be either by taxation or by insurance." He urges that "There should be co-operation and indeed partnership between the public and the profession in dealing with the economic problems of medical service and with that large area in which medicine and economics intermingle." This book is a notable contribution to the study of this subject.

Hugh H. Wolfenden, of Toronto, an actuary of high standing, in *"The Real Meaning of Social Insurance,"* elucidates many different aspects of medical economics. In the chapters on "The Desirable Features of, Advantages in, and Arguments for State Insurance," and the opposed side of the case, he presents the various arguments pro and con with great force and clarity, in fact in an age gone mad on the socialization of services, the potent arguments adduced by Mr. Wolfenden in opposition to state medicine, might well cause over enthusiastic supporters of this system to pause in its advocacy.

In the opinion of the writer quite the best presentation he has seen relating to health insurance is set forth in *"The Way of Health Insurance"* by A. M. Simons and Nathan Sinai, issued under the auspices of the American Dental Association. This work should be read by all who have an interest in medico-economic problems. In keenness of observation, lucidity of statement, and judicial outlook, this little volume leaves little to be desired. All the controversial points that are the subject of interest, or heated argument whenever medical men foregather, are dealt with. *"The Way of Health Insurance,"* is a real contribution to the rapidly increasing tide of literature relating to this subject. The authors assert that "Social Insurance has been very much oversold, and had tended to be looked upon as a cure-all for both poverty and sickness in the classes within its scope. That it has never lived up to these expectations does not necessarily prove that it does not have a place and a part in a well-rounded health programme;" that

"Insurance is the only one possible way of providing the necessary wider distribution of the cost of health care among the under-paid. The possible expansion and development of other; especially already tested methods, should be carefully considered; and, if insurance then seems desirable, it should not be permitted to dominate all other forms of service, but should be confined strictly to the purpose of meeting the cost of medical care for those who cannot meet the cost individually;" and that

"In spite of its name and all that may be said to the contrary, the dominant motive in the establishment of every system of health or sickness insurance, is the relief of poverty, not the preservation of public health." In other words the motive is economic rather than medical.

The *"Survey of Nursing Education,"* by Dr. Weir, is a monumental work, covering every phase of nursing, and in addition several matters that may be considered outside the scope of such an investigation, thus in this most authoritative tome of nearly 600 pages, we find a section devoted to state health insurance.

The close association of nurses and doctors in the care of the sick, and their intimate co-operation and interdependence in many fields, justifies the recommendation that this work should receive a careful and sympathetic reading by the members of the medical profession.

The *"Final Report of the Royal Commission on State Health Insurance and Maternity Benefits,"* of British Columbia, which has recently been issued, represents a Herculean task that has taken several years, and an expenditure of $24,000 to complete. The Conclusion of the Commission will be of interest to all who are concerned with the problems of medical care, and reads as follows:—

"Finally, we would say that our recommendations for the early establishment in British Columbia, of a suitable compulsory health-insurance plan, including maternity benefits, are the result of the members of our Commission having become imbued with the incalculable beneficial effects which kindred schemes in the Old World are producing in alleviating for the poorer classes the dread incubus of sickness costs, and thereby reducing premature mortality and raising the general standard of health among the masses. After entering upon as exhaustive a study of this problem as it has been possible, in the limited time at our disposal, we finish our labors and emerge from our inquiry with the following conclusions definitely established by the evidence. Without health and the means of preserving it, the usefulness of human life is seriously impaired, and apart from the unhappiness morbidity inflicts upon the individual, and indirect, but nevertheless trenchant economic loss is imposed upon the community the moment earning power is injured. With the development, side by side, with curative measures, of a sickness-preventive service, an ideal system will be set up for the effectual handling of what may be properly described as the greatest benefit to mankind — the maintenance of good health. In this direction also lies in large measure the solution of the problem surrounding the present and constantly increasing unsatisfactory condition of hospital finance, which to say the least is an appalling spectacle in an institution so vital to the health and well-being of the public."

"The Purchase of Medical Care, Through Fixed Period Payments" has just been issued by the National Bureau of Economic Research of New York. An institution whose object it is "To ascertain and present to the public important economic facts and the interpretation thereof in a scientific and impartial manner free from bias and propaganda."

This publication discusses in detail a number of plans in actual operation,

under which, individuals who do not come within the scope of the workmen's compensation laws, are assured of medical and hospital care for fixed amounts paid periodically.

It is recorded that in the United States 540,000 mining and lumber employees have "company" medical service available for them, that 530,000 railway employees are entitled, on a wage deduction basis, to complete care in employee association hospitals, and that the amount distributed by various unions in the form of sickness benefits in 1929 was $2,831,936. These figures indicate very strikingly the trend of the times, and the wide acceptance of the fixed period principle for the payment of medical services.

Finally, I should like to direct the attention of the readers of the *Bulletin* to the very admirable valedictory address of the immediate Past-President of the Canadian Medical Association, *Dr. A. S. Monro of Vancouver, in which he sets forth certain conclusions, among which are the following:—

1. There is an outstanding problem facing the medical profession to-day which must be solved by the profession, or else someone else will solve it for them.
2. Able medical leadership, backed by an active study in Economics is a prime need in every community, if a solution satisfactory to all is to be reached.
3. The "Insurance Principle" as applied to health service is both logical and sound.
4. The medical profession should devise means for the adequate medical care of the part pay patient.
5. Voluntary medical aid organizations in industry and the low salaried class, should be encouraged and developed on sound economic principles.
6. Compulsory health insurance is coming,—let us be well prepared to meet it when it arrives.

If the conclusions of Dr. Monro are sound, and I believe they are, is not the responsibility of organized medicine in Manitoba to plan to influence its own destiny, by constructive suggestions, the adoption of sound economic policies, and the presentation of a united front to any government, or municipal body that seeks to enforce, ill considered schemes that may impose unfair regulations upon medical practitioners, and prove of little value to the public.

As I see it the most immediate need which confronts us is the appointment of a full-time official to look after our interests, and to co-ordinate the activities of the various bodies organized to attend to our business. Such a plan is in operation in British Columbia and Alberta, and is said to give every satisfaction.

The forthcoming meeting of the Manitoba Medical Association should be taken advantage of to discuss the problems of Health Insurance.

*The many friends of Dr. Monro throughout the Dominion will have learned with profound regret of his untimely death in Saskatoon on the 12th inst., en route to Vancouver after having attended the annual meetings of the Canadian and the British Medical Associations.

Dr. Monro was a distinguished graduate of the Manitoba Medical College in the class of 1896. He practiced for many years in Vancouver, to the upbuilding of whose medical institutions he has made a most notable contribution. His confreres selected him for the honorable post of President of the Canadian Medical Association for the year that has just concluded. The medical profession of British Columbia and especially Vancouver have sustained a great loss in the death of Dr. Monro, whose gifts of leadership, vision and capacity in his calling have been recognized throughout Canada.

Treat the man who is sick, and not a Greek name.—*Jacobi.*

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Current Medical Events

The Border Medical Society met at Melita on July 18th, 1932. A representative number of physicians attended.

Dr. John M. McEachern spoke on "Disorders of the Heart Beat," and Dr. H. D. Morse spoke on "The Treatment of Prostatic Obstruction." Doctor F. W. Jackson gave a short talk on "Preventive Medicine."

* * * *

The Brandon and District Medical Society, in conjunction with the North-Western District, held a meeting at Virden on August 10, 1932.

Dr. Lennox Bell spoke on "The Treatment of the Anæmias."

Dr. Digby Wheeler on "The X-Ray in Gastrointestinal Conditions."

There was a large attendance at this meeting.

* * * *

At a meeting of the Border Medical Society held at Melita on July 28th, Dr. W. O. Henry, Waskada, was appointed as their representative to the Executive of the Manitoba Medical Association for the coming season.

* * * *

X-RAY OUTFIT FOR DISPOSAL

Victor Bedside Unit, 110 volt, 60 cycle A.C. with view-box, developing and fixing tanks, hangers, etc. Details may be had from Noel R. Rawson, 306 Devon Court, Winnipeg.

* * * *

MEDICAL PRACTICE

The Swan Lake Board of Trade have written us regarding the securing of a doctor for that district. This district runs 21 miles to Pilot Mound, 18 miles to Holland and 30 miles West, the nearest doctor being at Somerset. It also includes an Indian Reserve which their doctor has always had. There is also a Drug Store, just recently built. For further particulars apply to Mr. Hartwell, Secretary, Swan Lake Board of Trade.

* * * *

SOUTHERN DISTRICT MEDICAL ASSOCIATION

A meeting of the Southern Manitoba Medical Association was held at Morden on Wednesday, July 13, 1932.

The programme was as follows:—

Reading of the minutes of the previous meeting by the secretary.

"Injection Treatment of Varicose Veins," by Dr. R. D. Ferguson, Pilot Mound.

"Gastric Hæmorrhage," by Dr. C. L. Blight, Miami.

"Treatment of Fractures about the Elbow," by Dr. A. F. Menzies, Morden.

"Treatment of Breech Presentation," by Dr. C. W. Wiebe, Winkler.

Every physician present took part in the lively discussions of the papers. The hearty appetite of the members at a supper which followed gave evidence of an afternoon well spent. —C. W. Wiebe, *Secretary.*

What is spoken of as a "clinical picture" is not just a photograph of a man sick in bed; it is a impressionistic painting of the patient surrounded by his home, his work, his relations, his friends, his joys, sorrows, hopes and fears.—*Francis W. Peabody.*

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News Items

— of —

Department of Health and Public Welfare

ARSENIC IN BAIT

When the grasshopper bait was first distributed, farmers were sceptical of its poisonous character; despite explicit printed instructions issued with each lot, they were careless in its disposal. In some cases the bait was spread in small heaps, instead of being scattered thinly; the sacks were dumped in the yard and not until the stock or the turkeys died did some farmers begin to realize the truth. Others contracted dermatitis through handling with ungloved hands, or through sitting on the sacks.

It is feared that cases of arsenical poisoning may arise in later months. Sacks of the bait may possibly have been placed alongside sacks of sugar and the arsenical solution have leaked through, and possibly this sugar may have been used for preserving fruit. This need not be the only channel of poisoning. Therefore we are bringing this matter to the attention of the practicing physicians so that they may bear this possibility in mind when faced with an obscure case, or outbreak of diarrhœa, vomiting or neuritis.

. . . . . .

THE PROTECTION OF INFANTS AGAINST DIPHTHERIA

It is generally recognized that the protection against Diphtheria should be administered to those of pre-school age. Toronto and other centres found it more convenient to commence the campaign in the schools, but have since recognized the wisdom of extending it to younger children, even to infants. Hamilton, Ontario, scored by including the pre-school child from the start and is now able to show a clean slate. A recent analysis, by Godfrey,[a] of the results obtained in various cities of the States, clearly shows the importance of protecting the pre-school population, and that only so can diphtheria be eliminated.

TABLE 1 shows the age distribution of the deaths occurring from Diphtheria in Manitoba during the six years, 1926-1931. A special indication has been made of the deaths occurring in infancy and in the pre-school period. Of the 23 deaths occurring in infancy seven were in the first three months of life; two in the second; five in the third; and nine between the ages of nine months and one year.

TABLE 1 DEATHS FROM DIPHTHERIA (Manitoba), 1926-1931

Age	AGE DISTRIBUTION 1926	1927	1928	1929	1930	1931	Total	Percentage
Under 1 year	6	6	1	2	3	5	23	6.1
1 to 5 years	41	39	33	32	13	20	178	47.3
0 to 4 years	39	34	28	28	15	19	163	43.3
5 to 9 years	31	36	19	21	11	21	139	37.0
10 to 14 years	14	11	5	6	6	4	46	12.2
15 to 19 years	2	1	2	1	1	0	7	1.9
20 years and over	5	5	2	3	5	1	21	5.6
	91	87	56	59	38	45	376	100.0

TABLE 2 shows the age distribution of cases notified in 1930 and 1931 from points in Manitoba outside Winnipeg. It is unfortunate that in so many cases reported ages were omitted.

TABLE 2 DIPHTHERIA CASES (Manitoba), OUTSIDE of WINNIPEG
1930-1931

AGE DISTRIBUTION

Age	1930	1931	Total	Percentage
Under 1 year	6	5	11	.....
0 to 4 years	57	69	126	24.3
5 to 9 years	91	80	171	32.9
10 to 14 years	44	49	93	17.9
15 to 19 years	19	17	36	6.9
20 to 29 years	22	26	48	9.2
30 to 39 years	18	13	31	5.9
40 years and over	7	8	15	2.9
	258	262	540	100.0
Adults not known	7	2	9	
Children not known	7	6	13	
Not indicated	23	8	31	
	295	278	573	

The necessity for affording protection to the young child is evident. The general rule has been to start the course on, or shortly after, the first birthday, but the number of deaths before this age would indicate that the advisability of toxoiding the infants should be considered.

The reaction to the Schick test has been found by all investigators to be more frequently negative in infants than in older children, and it is generally assumed that this is due to immunity inherited through the placental blood from Schick negative mothers and that this immunity is gradually lost during the first years of life.

In an examination of one hundred mothers and their new-born babies, all under seven days of age, Ruh and McClelland[2] found that seventy-five Schick negative mothers had Schick negative offspring; twenty Schick positive mothers had Schick positive offspring; four Schick positive mothers had Schick negative offspring; one Schick negative mother had a Schick positive child. Of the Schick negative children eight had had no breast milk before the test was made.

From 1914 until 1921 Von Gröer and Kassowitch[3] published a long series of experiments in which they titrated the blood of infants and children for diphtheria antitoxin by the Römer method. In the cord blood of the new-born infant of mothers, immune to diphtheria, they constantly found antitoxin present to the amount of 1/200 unit or more per c.c. The antitoxin was retained longer by the breast-fed than by those artificially fed, indicating that some additional supply is transmitted through the milk.

On the other hand there is a possibility that the absence of the reaction is not in all cases due to the presence of antitoxin, but in some, at least, to an immature condition of the cells, which do not respond to the antigenic stimulus. That is, they are non-receptive to and uninfluenced by the diphtheria toxin, as are the cells of certain naturally immune animals, for instance the rat.[4] This may perhaps be the explanation of the negative reaction in the babies of four mothers who were Schick positive in the series of Ruh and McClelland, although, they, themselves, would attribute it to the difficulties of technique. Whatever the reason, it has been observed that in the early months when the Schick test is negative, there is a relative failure in attempts at inducing permanent immunity by the inoculation of toxoid or toxin-antitoxin.

In institutions for the care of infants it is feasible to perform the Schick test and start the inoculation of all Schick positive shortly after admission.[5] Save in the hands of those conversant with the test, the reading of the reactions is, however, by no means unequivocal, especially in infants.

Were we assured that inherited antitoxin is the sole cause of infant immunity it would be a useful alternative to test the mothers and immunize the infants of those Schick susceptible, or, where, as in rural Manitoba, there is a high percentage of non-immune adults, we might inoculate all infants; but, as we have seen, it is probable that in many cases the tissues would not have developed the power of response.

While, however, there may be two ways in which infants are immune, it seems to be well established that the offspring of Schick negative mothers are practically always Schick negative for the first six months; it is, therefore, suggested that all mothers should be immunized with toxoid during the first months of pregnancy and all infants during the eighth month of life.

To obviate the risk of inoculating a child who is still unresponsive through congenital passive immunity, it is advised that where practicable a preliminary Schick test be performed.

References: (1) Godfrey, Edward S., American Journal Public Health, March, 1932, 22, 237.

(2) Ruh, H. O. and McClelland, J. E., American Journal Diseases of Children, January, 1923, 25, 59.

(3) Von Groer and Kassowitch, Ztschr, F. Immunitatsforsch, u. exp. Therap. Mai, 1914, 23.108; ibid 1917, 26. 277, etc.

(4) Ramon, Noureddine and Eber, C. R. Soc. Biol., 1928.

(5) Greengard, Jos., J.A.M.A., July 25, 1931, 97.228.

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HEALTH FACTOR IN BACK TO FARM MOVEMENT

(Article taken from *"Illinois Health Messenger,"* Aug. 1, 1932)

"The farm population in the United States now is considerably more than half a million greater than it was a year ago, according to estimates made by the federal department of agriculture. This increase is independent of the movement which has taken thousands of families from cities to nearby suburban locations where rents are cheap and facilities for producing partial subsistance are available.

There are certain definite health risks involved in the entire movement away from the cities which are different from those encountered by the urbanite. Water and milk supplies in the cities are usually safe because of supervision by the city and state health authorities. In the country no supervision is exercised over private supplies. Families must be aware of the dangers and take precautions upon their own initiative. Contamination of both water and milk, when it occurs, results principally from human sources. Milk may be infected by a diseased cow, but this is unusual in Illinois. The well or spring water may be polluted by seepage from the privy if proper protection is lacking. Since the rural milk supplies are not pasteurized the danger of contaminated milk is greater than in the cities.

"Typhoid fever is now very largely a disease of the small community and farm. Even Diphtheria and Smallpox are coming to be relatively more prevalent in the rural than urban areas because the cities are gaining greater and greater control over these diseases. Lack of refrigerating facilities on the farm may make greater than in the city, especially to infants and young children, the risk of diarrheal diseases. At almost nominal costs these dangers may be effectively avoided by utilizing modern preventive methods. Typhoid fever, diphtheria and smallpox can be prevented by vaccination. Sanitation is also a preventive of typhoid. Diarrhea can be controlled by proper diet with wholesome food kept so by refrigeration and sanitation."

TYPHOID IN MANITOBA

This is the beginning of the Typhoid season. In 1931 there were reported in the four months—August to November—ninety-one cases of this disease in Manitoba; and investigation tends to show that in the spread of the disease in rural areas the main channel is the privy and the fly, the chief source the carrier — the man or woman, who continues to excrete the bacillus, after clinical recovery. It has been found on several different occasions that more than 5% of recovered patients continue to be carriers for an indefinite number of years, but that the risk is very much greater shortly after recovery than later.

Thus, in a recent survey, of 211 patients, 88 were still excreting the bacillus at the time of clinical recovery; 78, one month later; 24, three months later; 14, six months later; and 12, sixteen months later. Of the 12, nine were females. In at least one instance last year the evidence would show that the early discharge of a patient led to a fresh crop of cases in the district in Manitoba to which she was sent for convalescence.

It is suggested that before discharge the feces of all patients be examined twice at intervals of at least four days. If no typhoid bacilli are found, the patient should be warned that though his excreta are apparently normal, it is possible that he may yet be of some danger to his associates unless he is particularly careful in the disposal of his feces and urine and in his personal hygiene. Should bacilli be found on either occasion, he should be warned that he is a definite danger, and that not only must his personal hygiene and the disposal of his excreta be faultless, but that he should not handle milk or other food intended for the consumption of others. His excreta should be again examined three months and six months after his recovery; not until at least three examinations have failed to show the presence of bacilli should he be allowed to engage in the handling of milk or food.

The health officer of the municipality in which the discharged patient resides or intends to reside should be warned of his illness, and informed of the findings of the examinations made before discharge; it may, then, be his duty to see that the later examinations are made when required.

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COMMUNICABLE DISEASES REPORTED

Urban and Rural - July, 1932

Occurring in Municipalities of:—

Measles: Total 70—St. James 32, Winnipeg 23, Turtle Mountain 3, Coldwell 2, Cypress North 2, Kildonan West 2, Minnedosa 1, Shellmouth 1, Swan River Town 1, St. Andrews 1, Tuxedo 1, Winnipeg Beach 1.

Whooping Cough: Total 57—Winnipeg 43, Brandon 11, North Cypress 1, Melita 1, St. Boniface 1.

Tuberculosis: Total 46—Winnipeg 18, St. Laurent 9, Eriksdale 4, Grandview Town 2, Unorganized 2, Brandon 1, Chatfield 1, Dauphin Rural 1, Grey 1, Hanover 1, Lakeview 1, Portage Rural 1, Stanley 1, St. Clements 1, The Pas 1, Woodlea 1.

Scarlet Fever: Total 31—Winnipeg 9, St. Boniface 5, Armstrong 3, Argyle 2, Coldwell 2, North Norfolk 2, St. James 2, Brooklands 1, Charleswood 1, Rockwood 1, St. Laurent 1, St. Vital 1, Unorganized 1.

Chickenpox: Total 29—Winnipeg 17, Oak Lake Town 4, St. James 3, Unorganized 2, Sprague 2, Rivers Town 1.

Diphtheria: Total 17—Winnipeg 9, Fort Garry 2, Grey 1, Portage City 1, St. Boniface 1, St. Rose Rural 1, Transcona 1, Unorganized 1.

Mumps: Total 6—Winnipeg 6.

Typhoid Fever: Total 4—Grandview Rural 1, Stanley 1, St. Boniface 1, Winnipeg 1.

Cerebrospinal Meningitis: Total 2—Birtle Rural 1, Siglunes 1.
Erysipelas: Total 2—Winnipeg 2.
Smallpox: Total 2—Glenwood 1, St. Vital 1.
Trachoma: Total 2—Rhineland 2.
Cancer: Total 2—Rosedale 2.

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DEATHS FROM ALL CAUSES IN MANITOBA
for Month of June, 1932

URBAN—Cancer 27, Congenital 15, Tuberculosis 7, Pneumonia (all forms) 5, Puerperal 3, Influenza 1, Stillbirths 13, all other causes 123. Total, 194.

RURAL—Congenital 32, Tuberculosis 19, Cancer 17, Pneumonia (all forms) 12, Diphtheria 2, Influenza 2, Stillbirths 22, all other causes 141. Total, 247.

INDIANS—Tuberculosis 14, Pneumonia (all forms) 4, Congenital 2, Cerebrospinal Meningitis 1, Stillbirths 1, all other causes 2. Total, 24.

Manitoba Medical History

By Ross Mitchell

THE RED RIVER EXPEDITION OF 1870

(Continued from Previous Number)

The Lower or Stone Fort is twenty-one and a half miles by road from Fort Garry, and stands on the left bank of the river. It is a square enclosure, with large circular bastions at each angle, the walls being of substantial masonry and loopholed throughout. There is a good steam-mill, where the Hudson Bay Company grind all the flour they require in this northern department. The stone used in all these buildings is quarried from the bank on which the Fort stands, which is there about forty feet high. We discharged all surplus stores here, retaining only enough provisions for a few days, so as to lighten our boats as much as possible. A company of the 60th Rifles was mounted on ponies and in carts, and extended as a line of skirmishers on the left bank, with orders to keep well ahead, but always in communication by signallers with the boats. An officer on horseback was sent to examine the right bank, so as to protect us from surprise there, although there was little chance of any opposition being attempted on that side, even should Riel intend fighting. That bandit potentate, according to the news of the day before from Fort Garry, was still in the Fort, awaiting the arrival of his friend Bishop Taché, who was hourly expected. Strict watch and guard was still maintained by his armed followers, whose numbers varied constantly. We took every possible precaution to prevent intelligence of our arrival in the river from reaching Fort Garry. No one was permitted to pass in that direction, although every one was allowed to come within our line of skirmishers. This was done so successfully, that although we halted for the night at only six miles from the place, Riel did not know positively that we were in the river. A vague report of some boats with men in them being on their way up towards the Fort had reached the village of Winnipeg; but there had been so many previous rumours of a similar nature from week to week in the two preceding months, that no one credited it. We subsequently ascertained that Riel and O'Donoghue rode out late at night in our direction; but heavy rain coming on as they approached our pickets, and being in dread of capture, they returned without any certain information regarding us.

As we bent over our fires at daybreak, trying to get some warmth for our bodies, and sufficient heat to boil the kettles, a more miserable-looking lot of objects it would be impossible to imagine. Every one was wet through; we were cold and hungry; our very enemies would have pitied our plight. A hurried breakfast of tea and biscuit was soon over, and we were again in the boats by 6 a.m., rowing in three columns towards Fort Garry, as upon the preceding day. It poured heavily, and the country was at places a sheet of water, through which our skirmishers on the banks had to wade as best they could. As we approached the Protestant cathedral, the union-jack was run up to the steeple, and its bells rang out a musical welcome to the expeditionary force. The left bank was neatly cultivated and well settled, the population being entirely of English and Scotch descent. The other bank was a tangled mass of poor timber, and an under-brush consisting of hazel and rose bushes, intertwined with Virginia creeper. The moderately-rapid current in the river has, in the course of ages, cut out for itself a canal-like channel, which averaged from 150 to 300 yards in width. The floods in spring, when the ice breaks up, have in the last twenty years doubled in some places the distance between the banks, which are of most tenacious clay, steep throughout, and generally about thirty feet high. We landed at a place called Point Dougles on the left bank, where the river makes a great bend to the east-ward; so that, although it is only about two miles by road to the Fort, it is about six there by river. Our skirmishers had collected a few carts and horses, sufficient for the conveyance of some tools, ammunition, &c., &c. The guns were fastened by their trails to the rear of carts, and dragged along in that manner. Messengers who had been sent on the previous evening to the village of Winnipeg joined us here with information that Riel and his gang were still in the Fort, and that the current rumour was that he intended to fight. He had distributed additional ammunition amongst his men, and the gates were closed and the guns loaded.

The men were quickly ashore, and advanced towards the Fort under cover of a line of skirmishers. It was heavy work marching through the deep mud with a driving rain beating in our faces, making it very difficult to see more than a few hundred yards before us. Notwithstanding all these drawbacks, the men's pace was most elastic, and they were in the highest spirits at the prospect of a fight, which all the inhabitants we encountered now assured us we were certain of having. The village of Winnipeg is a small collection of houses, chiefly of wood, situated about 800 yards north of the Fort, with which a straight road connects it. The Fort is in the right angle formed by the junction of the Assiniboine with the Red River, being north of the former, and west of the latter stream. It was known that there was a boat-bridge over the Assiniboine, immediately opposite the southern gate of the Fort. It was therefore desirable to draw our line of attack round it, so as to command the two rivers, and so getting the enemy into the corner formed by them, prevent his escape.

Instead, therefore, of passing directly through the village, we swept round to the west, leaving it on our left; and when clear of it, swung round our right with the intention of taking up a position commanding the bridge. The people in the village assured us that Riel was in the Fort, and intended to resist. Several were asked to go forward in advance of our skirmishers, to ascertain if the southern gate was closed and the walls manned; but all feared to do so. As we passed the village we could see the guns in the embrasures bearing in our direction. Some people in buggies were described going off from the Fort westerly, but were brought to a halt by our skirmishers. They proved to be some of Riel's counsellors; but nothing could be

learned from them. The atmosphere was so thick that it was difficult to make out, even with our glasses, whether men were or were not standing to the guns which we saw. We expected every moment to see a puff of smoke from an embrasure, to be followed by the whizz of a round-shot past our heads. Every moment increased the excitement; the skirmishers quickened their pace as they neared the place, as if in dread lest others should enter it before them. Everything remaining silent, some staff officers were sent galloping round to see if the southern gate was open, and what was going on in rear of the Fort. They soon returned, bringing word that it was evacuated, and the gates left open.

This was at first a sad disappointment to the soldiers, who, having gone through so much toil in order to put down the rebellion, longed to be avenged upon its authors. Our victory, although bloodless, was complete. We dragged out some of the rebel guns, and fired a royal salute as the union-jack was run up the flagstaff, from which had floated, for so many months, the rebel banner that had been worked for Riel by the nuns in the convent attached to Bishop Taché's cathedral. The scene inside the Fort was most depressing; the square in front of the principal house was under water, and there was mud and filth everywhere. Riel and some of his friends had remained in the Fort up to the last possible moment, and had only left when they saw our skirmishers. Their breakfast was still on the table; and their clothes and arms lay scattered about through the numerous houses they had occupied, in a manner denoting the suddenness of their departure.

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(From the *Free Press* Files)

FIFTY-FIVE YEARS AGO—July 4, 1877

The Sisters of Charity, St. Boniface, had purchased the Clarke property, and proposed to use the fine residence as a hospital.

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TWENTY-FIVE YEARS AGO—June 28, 1907

The beautiful chancel window in Holy Trinity church, erected to the memory of the late Sir John Schultz, long a member of the church, was unveiled.

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THIRTY-FIVE YEARS AGO—July 2, 1897

Handsome donations had been received by the Winnipeg General Hospital directors toward the new jubilee wing of the hospital.

COMMERCIALISM VERSUS PROFESSIONALISM

We do not know whether this title is fairly descriptive of the idea we are endeavoring to express here. Our observation is that for many years the profession of Pharmacy has experienced much travail in its effort to remain a profession. Its necessarily close association with the commercial enterprise known as "the drug store," or "the pharmacy," or what not, principally the first named, has presented complications difficult if not impossible to overcome. What has happened is familiar to most of our readers. That is another story.

Some years ago, manufacturers of pharmaceuticals stumbled into this same boghole, from which it has been partially excavated by the medical

Warning

Once again, may we take this opportunity of bringing to the notice of the medical profession the attempts which are being made to substitute imitations for the original Antiphlogistine.

Imitators who are trying to foist deceptive substitutes upon the market are trading upon the good name of the original preparation and upon the confidence that physicians have reposed in it.

With the inducement of greater profits to those who will handle his product, the counterfeiter is well aware that his product is of inferior composition, little caring that his nefarious practice strikes at the very health of the patient.

The excellence of its formula — well-known to the medical profession — the quality of its ingredients and the preliminary treatment to which they severally are subjected, as well as the actual method of compounding, all contribute their share towards the high efficacy of Antiphlogistine.

In order to avoid the disappointment which inferior imitations inevitably will provoke, physicians are earnestly requested to prescribe Antiphlogistine in the original, unopened package.

The Denver Chemical Mfg. Company

153 LAGAUCHETIERE STREET, W.

MONTREAL

Antiphlogistine is Canadian-made.

profession, through the Council on Pharmacy and Chemistry of the American Medical Association. That is also another story, and an interesting one.

Another phase of the general problem has just come to our attention, quite accidentally. One of the large manufacturers of a product extensively prescribed by practicing physicians, and extensively used for that reason, was, it seems, told by the representative of a powerful drug chain organization that it must make certain concessions to "modern merchandizing methods," or else—. The first thing wanted was an extra discount. This was needed in order that the products in question might be advertised to the public. The advertising was deemed necessary in the interest of both the manufacturer and the chain organization which proposed to handle the products in question. The answer of the manufacturer was that he did not desire to advertise his products to the public. He prided himself that he advertised only to the medical profession. He felt that the public had no business prescribing for itself, even such a good product as he made.

The retailer urged that goods such as those in question could be sold in larger quantities by displaying them in windows, advertising them in newspapers, and by the recommendation of clerks. The manufacturer did not want any of those procedures followed. His products were marketed only upon the prescriptions of physicians, for which reason the container did not even carry dosage directions. It was felt that the patients must get the necessary instructions from the physicians. The retailer urged that the manufacture was hiding his candle under a bushel; that doctors were stupid, and do not know as much about the real value of the products in question as the clerks in the stores could be made to know; that the patients now make inquiries of these same clerks for advice in such matters. The retailer promised that if formulas and information were placed in the hands of clerks, and the suggested advertising methods followed, the goods in question would sell as they never had sold before.

The manufacturer refused to accede, and the chain-store concern threatened to break the manufacturer and, we are told, an effort is being made to make good the threat. An edict has gone to all clerks to dispense the product of another manufacturer. In none of this large number of drug stores may the product of this manufacturer be had except definitely named in the prescription of a physician.

We hope we have made the case clear. It is a difficult story to tell in a few words.

We are interested because this appears to be one of the many instances where the practicing physician is supposed to let others do their thinking for them. It seems to be true that commercial interests, because their affairs are dealt with in terms of money, should prevail over purely professional interests. The professional man emphasizes service rather than money, which, in the eyes of the financial magnate, is fatal. This is true not only in the manufacturing game, but in every other phase of finance touched by the professional man, particularly the physician.

We need only to look around a bit to identify any number of schemes whereby the doctor may be circumvented. Most all of the popular remedies, proprietary foods, and the like, have been popularized by the medical profession. Generally the doctor tells his patient to get some of this, that or the other drug or food, and take it. The patient goes ahead and, having followed the advice of the doctor that far, does not hesitate to follow the later and more intimately given advice of a clerk in a drug store. And the doctor stands for it. And generally the manufacturer stands for it. And why should the manufacturer be troubled when the doctor is not? The truth of the whole

business is, that not all doctors agree to the idea, and we know of a few instances in which the manufacturer chooses to lose materially by holding to the same ethical standards.

It seems that the medical profession is going to be driven to prescribe products by proprietary name, or at least give the name of the manufacturer, if they would avoid a number of substitute products. That is unfortunate, too, for the reason that many products widely used by the medical profession are properly made by a number of manufacturers. The doctor should not be required to insist that the patient have a product made by a certain manufacturer if the same product is made by a number of reputable and high-class manufacturers and sold to the public in an ethical manner. If it has to be otherwise, it will simply have to be so, and that seems to be about all there is to it.

Some of our readers will remember that some ten years ago the subject of prescribing aspirin was before us for discussion. A decision of a court was to the effect that if a patron goes into a drug store and asks for "aspirin," the druggist may supply him with any reliable brand of acetylsalicylic acid, the presumption being that the said patron is not familiar with the chemical name of the drug and does not, therefore, necessarily desire to be supplied with the product made by the manufacturer originally owning the copyright name. On the other hand, a patient taking a prescription for "aspirin," by that name, into a drug store to be filled, must receive the product made by the original owners of the copyright name, on the ground that the physician knows the technical designation of the drug, and if he wanted to leave it to the druggist he would have used that designation instead of the copyright name. This is a distinction and a difference. The rule will apply to other proprietary remedies. Whether it complicates the situation or eases it a bit, is hard to determine.

Perhaps the gist of our advice is that the doctor determine what it is he wants, and see to it that his druggist furnishes it. There are probably a number of methods of getting results in each instance.

—*Texas State Journal of Medicine*, Feby., 1932.

CLINICAL MEETINGS

At Brandon General Hospital—
2nd Wednesday at 12.30 p.m.

At Brandon Hospital for Mental Diseases—
Last Thursday. Supper at 6.30 p.m.
Clinical Session at 7.30 p.m.

At Children's Hospital—
1st Wednesday.
Luncheon at 12.30 noon.
Ward Rounds 11.30 a.m. each Thursday.

At Misericordia Hospital—
2nd Tuesday at 12.30 p.m.

At St. Boniface Hospital—
2nd and 4th Thursdays.
Luncheon at 12.30. Meeting at 1.00 p.m.
Ward Rounds 11.00 a.m. each Tuesday.

At St. Joseph's Hospital—
4th Tuesday.
Luncheon at 12.30. Clinical Session 1.00 to 2.00 p.m.

At Victoria Hospital—
4th Friday.
Luncheon at 12.00. Meeting at 1.00 p.m.

At Winnipeg General Hospital—
1st and 3rd Thursdays.
Luncheon at 12.30. Clinical Session 1.00 to 2.00 p.m.
Ward Rounds 10.00 a.m. each Thursday.
Pathological Conference at Medical College at 9.00 a.m. Saturday during college term.

Winnipeg Medical Society—
3rd Friday, Medical College, at 8.15 p.m.
Session: September to May.

Eye, Ear, Nose and Throat Section—
1st Monday at 8.15 p.m., at 101 Medical Arts Building.

DURING THE DEPRESSION

First Thought — Breast Milk

In addition to its many proved advantages over artificial feeding, breast milk during this time of financial stress has the advantage of economy. Breast milk is not only the best milk any baby can have, but it is also the least expensive feeding at the mother's command. It is also the most convenient feeding. It requires no mixing, sterilizing or warming.

WHEN breast milk fails, or when the mother's physical condition makes breast feeding inadvisable, a formula of cow's milk, water and Dextri-Maltose — adjusted by the physician to the infant's individual and changing requirements — is the next choice. Dextri-Maltose is readily assimilable with marked freedom from tendency to cause intestinal fermentation and upset; it is bacteriologically clean, it is supplied in dry powder form not readily subject to contamination. For three decades, its consistent clinical results have been known to physicians. In addition to these advantages, it costs but a few cents a day, so that it is within the reach of almost every mother even during the depression.

As a means of prolonging the infant's term at the breast, Casec (calcium-caseinate) is indicated as an antifermentative in colic and the mild diarrhoeas of breast-fed infants. Given in small amounts prior to nursing, its effectiveness is promptly manifested in most cases. Detailed literature and samples available to physicians, upon request.

Mead Johnson & Company, of Canada, Ltd.

Belleville, Ontario, Canada

Exponents of Baby Feeding by Physicians